**MEDDAC/DENTAC Regulation 40-24**

**Medical Services**

# Code Blue

**Headquarters**
**U.S. Army Medical Department Activity**
**Fort George G. Meade**
**2480 Llewellyn Avenue**
**Fort George G. Meade, MD 20755-5800**
**10 December 2002**

**Unclassified**

# *SUMMARY of CHANGE*

MEDDAC/DENTAC REG 40-24
Code Blue

Specifically, this revision—

- Has been published in a new format that includes a cover and this "Summary of Change" page.
- Reformats the title page. The Contents section now includes the page numbers that the various chapters and paragraphs begin on.
- Changes the title "Chief Nurse" to "Deputy Commander for Nursing".
- Moves the listing of required and related publications and referenced forms from paragraph 1-2 to appendix A.
- Changes the title "Chief, Surgical Services" to "Chief, Department of Specialty Care".
- Removes the Cardiology Clinic and adds the Musculoskeletal Center in place of the Physical Therapy and Orthodedic/Podiatry clinics from the list of activities without crash carts (table 2-2).
- Removes the internist from the membership of the Code Blue Team and makes the Medical Officer on Duty (MOD) responsible for directing ACLS efforts, which the MOD was formerly tasked to do in the absence of the internist (para 3-2).
- Removes the provision stating that a physician who is not an internist or MOD may elect to transfer supervision of the Code to the internist or MOD upon arrival (para 4-3).

**Department of the Army**
**Headquarters**
**United States Army Medical Department Activity**
**2480 Llewellyn Avenue**
**Fort George G. Meade, Maryland 20755-5800**
**10 December 2002**

*** MEDDAC/DENTAC Regulation 40-24**

**Medical Services**

# Code Blue

FOR THE COMMANDER:

DAVID A. BITTERMAN
*LTC, MS*
*Deputy Commander for Administration*

PATRICE E. GREENE
*COL, DE*
*Commanding*

Official:

JOHN SCHNEIDER
*Adjutant*

**History.** This is the second revision of this publication, which was originally published on 31 May 2000.

**Summary.** This regulation covers policy and procedures for conducting actual and test Code Blues.

**Applicability.** This regulation applies to Headquarters, U.S. Army Medical Department Activity, Fort George G. Meade (MEDDAC) (that is, Kimbrough Ambulatory Care Center (KACC) and Dental Clinic Number 3 (DC#3) of the U.S. Army Dental Activity, Fort George G. Meade (DENTAC)).

**Proponent.** The proponent of this memorandum is the Chief, Department of Primary Care.

**Supplementation:**
Supplementation of this regulation is prohibited.

**Suggested improvements.**
Users of this publication are invited to send comments and suggested improvements, by memorandum, directly to the Commander, U.S. Army Medical Department Activity, ATTN: MCXR-DPC, Fort George G. Meade, MD 20755-5800, or to the MEDDAC's Command Editor by fax to (301) 677-8088 or e-mail to john.schneider@na.amedd.army.mil.

**Contents** (Listed by paragraph and page number)



* This publications supersedes MEDDAC/DENTAC Reg 40-24, dated 10 October 2001.

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**Contents–continued**



**Appendixes**



**Table List**



**Glossary**

**R-Forms**

## Chapter I
## Introduction

### 1-1. Purpose
This memorandum mandates the responsibilities, policies and procedures of the Code Blue Team which provides care to patients who require, or might require, cardiopulmonary resuscitation and/or other emergency medical services such as IV line placement, ventilation, and oxygen therapy at KACC during scheduled hours of operation. This policy applies to all KACC staff members.

### 1-2. References
Required and related publications are listed in appendix A. Prescribed and referenced forms are also listed in appendix A.

### 1-3. Explanation of abbreviations
Abbreviations and special terms used in this memorandum are explained in the glossary.

### 1-4. Responsibilities
a. *The Emergency Medical Services (EMS) Medical Director*. The EMS Medical Director will update the Code Blue System as required and in accordance with (IAW) the latest evidence-based guidelines.

b. *The Chief, Pharmacy Service*. The Chief Pharmacy Service will ensure that all crash carts are standardized IAW this regulation.

c. *Clinic chiefs*. Clinic chiefs will ensure that training on Code Blue procedures is conducted and documented on a quarterly basis.

d. *The Code Blue Assessment Team (CBAT)*. The CBAT will periodically review, and update as required, the policies and procedures pertaining to the Code Blue and standardization of standard crash carts and provide this information to the EMS Medical Director for inclusion in revisions to this regulation. Members of the CBAT include the EMS Medical Director, the Chief, Primary Care Nursing, the Chief, Anesthesia Service, and other services as needed for their input and expertise.

## Chapter 2
## General

### 2-1. Team response to cardiopulmonary arrest
When responding to a cardiopulmonary arrest, a team approach must be established and systematically followed by all healthcare staff who are involved.

### 2-2. Basic Life Support (BLS) and Advanced Cardiac Life Support (ACLS) qualifications
All staff involved with direct patient contact are required to be BLS certified every two years. The Code Blue Team members are required to maintain a current ACLS card. Pediatricians on the Code Blue Team are required to maintain a current PALS card.

## 2-3. Locations of crash carts

Locations of crash carts within KACC are determined by the MEDDAC Commander and are as specified below in table 2-1 . Locations without crash carts are identified in table 2-2.

**Table 2-1**
**Activities with crash carts**

| Activity | Number of crash carts |
|---|---|
| Dental Clinic No. 3 | 1 |
| Operating Room | 1 |
| Pediatric Clinic | 1† |
| Pharmacy | 1‡ |
| Post Anesthesia Care Unit | 1† |
| Radiology | 1 |
| Same Day Surgery | 1† |
| Specialty Clinic | 1 |
| White Team/After Hours Clinic | 2§ |

† These clinics have Braselow-Hinkley Pediatric Resuscitation Kits as a supplement to the standard crash cart with pediatric equipment.
‡ The Pharmacy maintains a backup cart for release while restocking another cart.
§ One standard crash cart and one training cart. The training cart is only to be used in approved training exercises.

**Table 2-2**
**Activities without crash carts**

| Activity without a crash cart | Location of the nearest crash cart |
|---|---|
| Allergy/Immunization Clinic | White Team/After Hours Clinic |
| Blue Team | White Team/After Hours Clinic |
| Community Health Nursing Section | Specialty Clinic |
| ENT/Audiology Clinic | Specialty Clinic |
| Musculoskeletal Center | White Team/After Hours Clinic |
| Operating Room | Post-anesthesia Care Unit |
| Physical Exams Clinic | Specialty Clinic |
| Red Team | White Team/After Hours Clinic & Dental Clinic #3<br>Specialty Clinic<br>Same Day Surgery |

## 2-4. Standardization of crash carts

a. The following equipment will be located on the outside of each crash cart:

(1) Defibrillator attached to the battery unit, which will be connected to the nearest AC outlet.

(2) A full roll of electrocardiogram paper, which will be kept in the monitor at all times.

(3) Suction apparatus with tubing and yankauer suction tip attached.

(4) Appropriate Code Blue paperwork, with clipboard, will be readily accessible on top of the cart.

(5) An oxygen tank with greater than 1000 pounds of oxygen per square inch of oxygen, regulator and tubing.

(6) Adult and pediatric Ambu bags with one adult and one pediatric face mask will be contained in a drawstring bag hanging from the IV pole attached to the cart.

(7) EKG leads.

(8) Defib/Pacing pads.
(9) Current copy of ACLS protocols.

b. Contents of the crash cart. (See appendixes D through H).

### 2-5. MEDDAC Form 396-R, Crash Cart Inspection Checklist

MEDDAC Form 396-R (Crash Cart Inspection Checklist) will be utilized during all daily crash cart checks. An entire month's crash cart checks will be entered on the same form. A new form will be started at the beginning of each calendar month. Information entered in columns "a" (Cart lock no.) and "b" (Cart expiration date) must be legible. Enter check marks in columns "c" through "j" to indicate the presence of the required items. The initials of the person conducting the inspection must be entered in column "k." MEDDAC Form 396-R is a reproducible form. Copies may be made when they are needed from the electronic forms section of the MEDDAC's web site (www.narmc.amedd.army.mil/kacc) or from the copy in the R-Forms section at the back of this regulation.

### 2-6. The Mock Code Blue Training Team (MCBTT) and mock Code Blue training

a. The MCBTT will consist of ACLS-trained representatives from Nursing Education and Staff Development (NESD), Department of Primary Care, and Risk Management.

b. Standardized mock Code Blue training will be conducted by members of the MCBTT. The training will be scheduled and participation documented at the clinic level on a quarterly basis. Areas that assess the need to conduct mock Code Blue training more frequently will do so. Scheduling of mock Code Blue training is the responsibility of the OIC, HN, and noncommissioned officer in charge (NCOIC) of the clinic.

c. All members of the clinical staff will be trained on the use of automated external defibrillators (AEDs) as part of their BLS recertification.

d. See appendix B.

## Chapter 3
## The Code Blue Team

### 3-1. Members of the Team

a. Normal duty hours. The Code Blue team will consist of the following personnel during the normal duty hours of 0730-1600, Monday through Friday (except holidays):

(1) The medical officer of the day (MOD).
(2) The nurse of the day (NOD).
(3) An Anesthesia Service staff member.
(4) A pediatrician (when designated as a pediatric code).
(5) A pharmacist.

b. Evening, weekend and holiday hours. The on-duty After Hours Clinic (AHC) physician will respond to a Code along with extended hours clinic staff at the Code location. Ambulance personnel, called to transport the patient, may assist during a Code if more personnel are needed or if the Code occurs outside of a clinic (for example, in a hallway or outside the building).

### 3-2. Responsibilities of Code Blue Team members

a. *The MOD*. MOD will—

(1) Direct ACLS efforts.

(2) In the absence of Anesthesia Service, intubate the patient if such is indicated.

b. *The NOD*. The NOD will—

(1) Bring the nearest available backup crash cart, if needed, to the Code site.

(2) Obtain IV access

(3) Administer medications and assist with ACLS protocols.

c. *The clinic RN and staff*. The clinic RN and staff will—

(1) Activate Code Blue procedure.

(2) Begin BLS.

(3) Obtain the nearest crash cart.

(4) Call for an ambulance.

d. *The Anesthesia Service staff member*. The Anesthesia Service staff member will provide airway support and intubate the patient if such is indicated.

e. *The pediatrician*. The pediatrician may direct the Code if the patient is 0-13 years of age.

f. *The pharmacist*. The pharmacist will assist with medication management and as needed during the resuscitation.

### 3-3. Code phones

All members of the Code Blue Team will keep their Code phones in working condition and turned on during normal duty hours. During normal duty hours, any team member who needs to leave the facility or is otherwise unable to respond in the event of a Code, will personally turn his or her phone over to another ACLS qualified individual who is capable of performing his or her functions on the Code Blue Team.

### 3-4. Responding to a Code Blue

When responding to a Code Blue, team members will respond directly to the location displayed on their pagers. (See appendix H.) Call the White Team/AHC if the location is other than those listed on the pager or if the location is not identified on the overhead page (the public address system).

## Chapter 4
## Initiating a Code Blue

### 4-1. Initial response to discovery of a patient with cardiopulmonary arrest

a. The first staff member who discovers a patient in a suspected, impending, actual cardiopulmonary arrest or other impending cardiovascular or respiratory emergency will call for assistance and initiate BLS while other staff members initiate the EMS and obtain the crash cart.

b. The staff will activate the code blue system by dialing “119” on any official telephone within KACC and announcing “Code Blue” with the exact location. If “119” is busy, hang up and dial again.

c. The staff will also call the KACC information desk at 7-8741, clearly state “Code Blue,” give an exact location, and instruct the person at the desk to immediately announce this

over the public address system.

d. If a Code Blue occurs in an area without a crash cart, the activity (or nearest activity) will send a runner to the nearest clinic that has a crash cart. (See table 2-2, page 2.) If the nearest clinic is locked, the runner will go to the AHC and get a crash-cart.

e. Staff members will also call for an ambulance/activate EMS by calling 7-3911/2570.

### 4-2. Procedure for activating the Code Blue Team

Immediately upon being notified of a Code Blue, the MOD will activate the Code Blue paging system per appendix H. The KACC Ambulance Section (7-3911) will be notified by the clinic staff that activated the Code Blue.

### 4-3. The Code Blue Team's actions in response to a Code

a. The first physician to arrive at the scene of the Code will take charge of the Code and supervise cardiopulmonary resuscitation (CPR), including BLS and ACLS.

b. Upon arriving at the scene of the emergency, the Code Blue Team will assist in the delivery of BLS and or ACLS.

c. In every situation, the physician supervising the Code will determine the extent of CPR and other emergency services rendered and where those services will be rendered (for example, at the scene or the AHC). The supervising physician will also determine if and when the patient is ready for transfer to a medical treatment facility (MTF) with an emergency room (ER). If the patient requires transportation to the ER of another MTF by paramedics, this will be accomplished as expeditiously as possible.

d. MEDCOM Form 679-R (Test), Emergency Resuscitation Record, will be completed during and after the Code. Completion of this form is self-explanatory. When completed, the form will be reviewed and signed by the nurse in charge and the Code team leader. The white copy will be placed in the patient's chart and the yellow copy will be forwarded to the Code Blue Assessment Team via Nursing Services. This form may be requisitioned from the MEDDAC Forms Control Officer.

### 4-4. Transportation of a Code patient to another MTF

a. The Ambulance Section will be notified at the start of the Code Blue process. If the paramedics are out, the call will be forwarded to the Fort Meade Fire Department and relayed to Anne Arundel County's EMS. The decision of when to transport the patient will be made by the physician supervising the code but the decision of where to transport the patient will be in accordance with Maryland EMS guidelines.

b. The physician will call the receiving MTF to report the status of the patient and determine the accepting physician prior to transfer.

c. All patient care documentation and advance medical directives, as appropriate and available, should accompany the patient to the gaining MTF.

d. After the patient's transportation has been completed, the paramedics will report back to the White Team with the identity of the MTF to which the patient was transported and the time of delivery and status upon arrival.

### 4-5. MEDDAC Form 688-R, Code Blue After Action Report

MEDDAC Form 688-R, Code Blue After Action Report, will be completed as soon as possible after termination of the Code by the senior nurse and team leader physician involved and routed

through the Code Blue Assessment Team, via Nursing Services, within 24 hours of the patient's resuscitation. Completion of the form is self explanatory. When they are needed, copies may be made from the copy in the R-Forms section at the back of this regulation.

## Chapter 5
## Protocol

### 5-1. Assuming leadership of the team
The first physician to arrive at the scene of the Code will take charge of the Code. If this physician is not an internist or the MOD, he or she may elect to transfer supervision of the Code to the internist or the MOD, depending on which arrives first.

### 5-2. Excessive staff
Excessive staff in the Code area may be asked to leave by any member of the Code Blue Team.

### 5-3. Staff responsibilities in the event of a patient's death
Staff responsibilities regarding patient death are covered in MEDDAC Memorandum 638-1.

### 5-4. Restocking of crash carts following a Code
a. Immediately following a Code, the clinic NCOIC will coordinate with the Pharmacy to borrow its second cart as a backup crash cart until the clinic's cart is restocked and relocked by the pharmacy.

b. The Pharmacy will then restock the used crash cart IAW appendixes D through H.

c. The restocked crash cart will be secured by the Pharmacy with a plastic lock and returned to the original clinic.

d. The borrowed crash cart will be returned intact to the Pharmacy.

## Chapter 6
## Code Blue System Tests

### 6-1. Initiation of Code Blue tests
Response to the Code Blue Nextel and overhead paging system will be tested weekly by the NCOIC of the White Team/AHC.

### 6-2. Response time
Once a Code Blue test is initiated, the Code Blue team members must respond to the page immediately. Response time to both overhead and beeper pages will be checked and annotated.

### 6-3. Failure to respond
Code Blue team members who fail to respond to a Code Blue test will be called by the NCOIC of the White Team/AHC to determine whether a page had been received. The appropriate department chief will be notified by the NCOIC of the White Team/AHC whenever a member of his or her department fails to respond to a test.

### 6-4. Crash cart checks
See appendix C.

### 6-5. Documentation of Code Blue tests
Documentation of responses to Code Blue tests will be maintained by the NCOIC of the White Team/AHC.

### 6-6. Replacement of faulty Code phones
Faulty Code phones will be corrected immediately by Information Management Division. A replacement Code phone will be issued if the problem cannot be corrected with a new battery.

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## Appendix A
## References

### Section I
### Required Publications

**MEDDAC Memo 638-1**
Decedent Affairs. (Cited in para 5-3.)

### Section II
### Related Publications
A related publication is merely a source of additional information. The user does not have to read it to understand this regulation.)

**AR 310-25**
Dictionary of United States Army Terms

**AR 310-50**
Authorized Abbreviations, Brevity Codes, and Acronyms

Comprehensive Accreditation Manual for Ambulatory Care, Joint Commission on Accreditation of Healthcare Organizations.

### Section III
### Prescribed Forms

**MEDDAC Form 396-R**
Crash Cart Inspection Checklist. (Prescribed in para 2-5.)

**MEDDAC Form 688-R**
Code Blue After Action Report. (Prescribed in para 4-5.)

### Section IV
### Referenced Forms

**DA Form 4106**
Quality Assurance/Risk Management Document

**MEDCOM Form 679-R (Test)**
Emergency Resuscitation Record. (This is a 3-page form. The third page is entitled Evaluation Tool for Emergency Resuscitation Record (ERR) ).

**Appendix B**
**Mock Code Training Plan and Assessment Tool**

### B-1. Mock Code training plan

Mock codes will be initiated by a NESD representative and the Chief, Department of Primary Care or Risk Management representative. On the day of a scheduled mock Code, the NESD representative and Chief, Department of Primary Care or Risk Management representative will report to the specified area with a mannequin and arrhythmia generator. After selecting an appropriate area for the equipment, the unit staff will be informed that the patient is unresponsive and needs assistance. Once the mannequin is attached to the arrhythmia generator, the initial Code will proceed and involve ventricular fibrillation. The Mock Code Assessment Tool on the next page will be used to assess the training.

This space intentionally left blank

**B-2. Mock Code Assessment Tool**

| | YES | NO |
|---|---|---|
| 1. Checked responsiveness | | |
| 2. Call for help, activate Code Blue - 119 | | |
| 3. CPR initiated within 2 minutes | | |
| 4. Closest crash cart to site | | |
| 5. Code team arrival and ACLS initiated within 5 minutes | | |
| ● MOD arrival | | |
| ● Anesthesia arrival | | |
| ● NOD arrival | | |
| ● Pharmacy arrival | | |
| 6. Did Code phone system function properly? | | |
| 7. Was the overhead page effective? | | |
| 8. Is documentation by recorder accurate? | | |
| 9. Was the resuscitation effort organized? | | |

Group Summary/lessons learned:

If a "NO" is obtained in areas 1 through 4, the unit will be rescheduled for a random mock Code evaluation within one month.

Completed mock Code evaluation will be given to the Chief, Department of Primary Care. Code phone system failures or overhead page failures will be reported to the Risk Manager on DA Form 4106 (Quality Assurance/Risk Management Document).

## Appendix C
## Crash Cart Exchange Program

### C-1. General
Units that have crash carts will be required to open them once each month, in accordance with the schedule in paragraph C-2 to ensure the staff are familiar with the cart's contents. Once the cart is opened, a unit representative will bring the cart to Central Medical Supply (CMS) to exchange it for a locked cart. If the cart is used during an actual Code or mock Code, the cart will be immediately exchanged in CMS. Do not bring hand-receipted items such as defibrillators or suction devices to CMS – bring only the cart.

### C-2. Exchange schedule
The schedule in table C-1 will be used by all units to avoid overwhelming CMS and the Pharmacy with the exchange process. Cars will only be exchanged between 0800 and 1500, Monday through Friday, except holidays. If your unit's assigned day falls on a weekend or holiday, you should conduct your cart review and exchange prior to the weekend or holiday.

**Table C-1**
**Crash cart exchange schedule**

| Unit | Day of month to conduct exchange |
|---|---|
| Specialty Services | 1 |
| Red Team, Family Care Center | 3 |
| Post-anesthesia Care Unit | 5 |
| Same Day Surgery | 7 |
| Radiology | 9 |
| Pediatrics | 11 |
| Dental Clinic No. 3 | 15 |
| White Team, Family Care Center/AHC | 17 |
| Blue Team, Family Care Center | 19 |

### C-3. CMS restocking responsibilities
CMS will ensure the returned cart is completely stocked with non-expired items and will place a label on drawer 2 (see appendix F), annotating the date of the next product expiration. CMS will contact a Pharmacy representative to deliver drawer 1 (see appendix E) to CMS. Drawer 1 will also have a label annotating the date of the next product expiration.

### C-4. Securing carts and tracking their locations
CMS will place a plastic lock on the cart and create a roster with the lock number and cart expiration dates. CMS will track cart locations when the carts are exchanged. CMS will maintain an exchange ready cart at all times. If a unit's cart is not exchanged on a monthly basis, within two weeks of the unit's scheduled date (see table C-1 above), CMS will report this finding to the Risk Manager on DA Form 4106. CMS will also report repetitive late turn-ins; i.e., more than three in a 12-month period, on DA Form 4106.

**Appendix D**
**Labeling of Crash Cart Drawers**

**MEDICATIONS**
Drawer No. 1

**IV / BLOOD**
Drawer No. 2

**ANESTHESIA EQUIPMENT**
Drawer No. 3

**Top Bin**
**Bottom Bin**
Sticker with expiration dates for various contents of the crash cart.

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**Appendix E**
**Crash Cart Stockage List for the Top Bin**

Laryngoscope handles: medium .....1 ea
Straight blades (Miller): Adult 2 and 3 .....1 ea
Curved blades (McIntosh): Adult 3 and 4.....1 ea
Stylette, Adult .....1 ea
Oral airways: Adult 80 and 90 .....1 ea
Endotracheal tube, adult cuffed 7 and 8.....1 ea
10cc syringe .....2 ea
Tongue blade.....1 ea
Disposable end-tidal CO 2 detector .....1 ea
Stethoscope .....1 ea
Micro shield for CPR .....1 ea
Adhesive tape, 1 inch.....1 roll
Tube securing device .....3 ea
Latex-free, powder-free gloves, medium and large ...1 box ea
Ambu bags, Adult and Child with face masks, will be maintained in a drawstring bag hanging from the IV pole on the cart.

**Appendix F**
**Crash Cart Stockage List for Drawer No. 1 – Medications**

Adenosine 3 mg/ml 2 ml vial.....2 Each
Amiodarone 150 mg/3 ml vial.....5 Each
Atropine Sulfate 1 mg 0.1 mcg/ml 10 ml syringe.....3 Each
Calcium Chloride 1 gm 100 mg/ml 10 ml syringe .....2 Each
Dextrose 50% 500 mg/ml 50 ml syringe .....2 Each
Diphenhydramine HCl 50 mg/ml 1 ml syringe.....2 Each
Epinephrine 1:10,000 0.1 mg/ml 10 ml syringe .....6 Each
Epinephrine 1:1000 (1 mg/ml) 30 ml vial.....1 Each
Flumazenil 1mg/10 ml 10 ml vial.....2 Each
Furosemide (Lasix) 100 mg/10 ml 10 ml vial .....1 Each
Lidocaine 2% (20 mg/ml) 5 ml syringe .....3 Each
Magnesium Sulfate 50% (500 mg/ml) 10 ml syringe.....1 Each
Metoprolol 5 mg/5 ml 5 ml ampule .....2 Each
Naloxone 0.4 mg/ml 1 ml ampule.....5 Each
Nitroglycerin SL 0.4 mg bottle .....1 Each
Nitroprusside Sodium (Nipride) 50 mg vial .....1 Each
Norepinephrine Bitartrate (Levophed) 1 mg/ml 4 ml ampule .....1 Each
Normal Saline 5 ml Carpuject Flushes .....20 Each
Procainamide 1000 mg/ml 10 ml vial.....2 Each
Sodium Bicarbonate 4.2 % (pediatric) 0.5 meq/ml10 ml syringe.....2 Each
Sodium Bicarbonate 8.4% (adult) 1 meq/ml 50 ml syringe.....2 Each
Sterile Water for Injection 50 cc vial.....2 Each
Vasopressin 20u/1cc vial .....4 Each
Verapamil (Calan) 5 mg 2.5 mg/ml 4 ml vial.....5 Each
Tubex Handle.....2 Each
Carpuject Handle .....2 Each
Male Adapters.....5 Each

**Premixed Medications (see appendix I) kept in Top Side Bin**

Dopamine 400 mg/250 ml D5W premix
Lidocaine 1 g/250 ml D5W premix
Nitroglycerin 50 mg/250 ml D5W premix
Heparin 12,500 U/250 ml D5W premix

**CONTINUED ON NEXT PAGE.**

**Appendix G**
**Crash Cart Stockage List for Drawer No. 2 - IV/Blood**

Angiocaths 14 g, 16 g, 20 g .....2 ea
Angiocath 18 g.....5 ea
18 g Needle INJ .....10 ea
22 g 1 inch Needle .....10 ea
Syringes (Luer lock ) 3cc.....2 ea
Syringes (Luer lock ) 10cc.....5 ea
Syringes (Luer lock ) 20cc.....1 ea
Syringes (Luer lock ) 50cc.....1 ea
Hypo needle 1 1/2 inch, 20 g .....6 ea
Spinal needle 3 1/2 inch, 18 g.....2 ea
Spinal needle 3 1/2 inch, 22 g.....1 ea
Alcohol wipes .....6 ea
Povidine iodine swabsticks.....2 ea
RED top blood tube .....2 ea
BLUE top blood tube.....2 ea
PURPLE top blood tube.....2 ea
Pediatric RED top blood tube .....3 ea
Pediatric PURPLE top blood tube .....3 ea
#10 or #11 Blade.....1 ea
Arterial blood gas kit .....3 ea
Blank labels.....5 ea
Three-way stopcock w/extension.....1 ea
Three-way stopcock.....1 ea
IV tubing reg drip (10-15gtt) (PRIMARY) .....2 ea
Blood component set (w/needle) ..... 1 ea
Gauze 4X4 .....5 ea
Gauze 2X2 .....5 ea
Micropore tape 1/2 inch.....1 roll
Micropore tape 1 inch.....1 roll
Adhesive tape 1 inch.....1 roll
Adhesive tape 2 inch.....1 roll
Penrose drain 5/8 inch.....2 ea
Tongue Blade.....2 ea

**Appendix H**
**Crash Cart Stockage List for Drawer No. 3 - Anesthesia Equipment**

(Note: All anesthesia/intubation equipment will be contained in a basin or bin that can easily be lifted out of the drawer.)

Laryngoscope handle, small and large.....1 ea
Straight blade (Miller): Pediatric 0 and 1 .....1 ea
Curved blade (McIntosh): Pediatric 1 and 2.....1 ea
Stylette, pediatric .....1 ea
Oral airway: Adult 100mm .....1 ea
Oral airway: Pediatric 43 and 60mm .....1 ea
MacGill forceps, Adult .....1 ea
MacGill forceps, Pediatric .....1 ea
Endotracheal tube, Adult 6, 7, 8, 9 .....1 ea
Endotracheal tube, Pediatric, uncuffed 2.5, 3, 3.5, 4, 4.5, 5, 5.5 .....1 ea
LMA 3, 4, 5.....1 ea
Syringe (Luer lock) 10cc .....2 ea
Combi tube set .....1 ea
E-tube securing device.....3 ea
Nasal airway 28, 30, 32.....1 ea
Tongue blade.....2 ea
Batteries for each handle.....2 ea
Extra light bulbs for blades.....2 ea
Cutdown tray.....1 ea
Infant and neonate disposable mask .....1 ea
Face masks for ambu bags: neonate.....1 ea
Face masks for ambu bags: infant.....1 ea
Face masks for ambu bags: child.....1 ea
8.5 or 9 Fr Percutaneous Introducer kit .....1 ea
Triple lumen catheter (7 or 8 Fr).....1 ea
Oxygen connector tubing.....1 ea
Oxygen connector (Christmas tree) .....1 ea
Yankuer suction tip.....1 ea
Suction tubing .....1 ea
Salem sump tube 14, 16, 18.....1 ea
K-Y lubricant, pkg or 1 tube.....3 ea
Toomey syringe 500cc.....1 ea
Y connector.....1 ea
Straight connector .....1 ea
02 wall gauge w/Christmas tree.....1 ea
Combi tube size 41.....1 ea
Combi tube size 37.....1 ea

## Appendix I
## Crash Cart Stockage List for the Bottom Bin and Side Bins- Personal Protective Equipment

### Bottom Bin

Normal saline irrigation solution 250cc.....1 ea
EKG pad.....1 pack
Pedi Quick Combo pad.....1 ea
Suction catheter 10, 12, 14 fr.....1 ea
Blood pressure cuff, Adult.....1 ea
Sterile gloves, size 7, 7 1/2, and 8.....2 ea
Sharps container.....1 ea
Face shield with mask.....2 ea
Splashproof gown.....2 ea
Latex-free, powder-free gloves, medium and large.....1 box ea
Quick Combo pad.....2 ea
Sterile gown.....1 ea
Regulated medical waste bag (red bag).....1 ea

### Side Bin 1

Dopamine Premix (400mg/250ml D5W; 1600mcg/cc) 1 ea
Lidocaine Premix (1 GM/250ml D5W; 4mg/cc).....1 ea
Nitroglycerin Premix (50mg/250ml D5W).....1 ea
Heparin Premix 12,500 units/250ml D5W (50u/cc).....1 ea

### Side Bin 2

IV solution NS 250ml.....2 ea
IV solution NS 500ml.....2 ea

### Side Bin 3

IV solution NS 1000ml.....2 ea

**Appendix J**
**Activating the Code Blue Paging System**

Immediately upon being notified of a Code Blue, the MOD will—

a. Activate Code Blue Paging System as follows:

(1) Lift the telephone receiver and press the autodial button labeled "Code Blue."

(2) Wait for the prompt that instructs to enter the pin #.

(3) Press the pin # key (Pin # 1940016)

(4) Listen for the prompt that instructs to enter the numeric message and wait for the beep.

(5) Enter the location code for the Code Blue by pressing the appropriate speed dial key or directly entering 999 + the number appearing in table J-1, below, that corresponds to the location.

**Table J-1**
**Code Blue location codes**

| Location | Location code |
|---|---|
| White Team/AHC | 1 |
| Operating Room | 2 |
| Post-anesthesia Care Unit | 3 |
| Same Day Surgery | 4 |
| Radiology | 5 |
| Specialty Clinic | 6 |
| Event Center | 7 |
| Red Team | 8 |
| Blue Team | 10 |
| Pediatrics | 11 |
| Physical Exams Clinic | 12 |
| Dental Clinic No. 3 | 13 |
| Physical Therapy Clinic | 14 |
| Community Health Nursing | 15 |
| Other | 16 |

(6) Press the pound sign (#).

(7) Wait for confirmation that your message was sent. You will hear "999-(number you input) will be sent."

(8) Hang up.

(9) Wait 30 seconds and repeat steps in paragraphs (1) through (8) above.

(10) When the system has been properly activated, the digits "999-X" will appear on the telephone's display panel. The "X" represents a location code from table J-1. Code keys are affixed to all Code phones.

b. In the event the Code Blue phone is not working, the Code phones may be activated from any phone by dialing 1-800-759-8888 and following steps in paragraphs a(2) through (7) above.

c. Announce the Code Blue over the public address system. Call the Information Desk (7-8392) and have the person on duty announce the Code Blue.

d. Notify the Ambulance Section by calling 7-3911.

## Glossary

### Section I
### Abbreviations

**ACLS**
Advanced Cardiac Life Support

**AED**
automated external defibrillator

**AHC**
After Hours Clinic

**BLS**
Basic Life Support

**CBAT**
Code Blue Assessment Team

**CMS**
Central Medical Supply

**CPR**
cardiopulmonary resuscitation

**DC#3**
Dental Clinic Number 3

**DENTAC**
U.S. Army Dental Activity, Fort George G. Meade

**EMS**
Emergency Medical Services

**IAW**
in accordance with

**KACC**
Kimbrough Ambulatory Care Center

**MCBTT**
Mock Code Blue Training Team

**MEDDAC**
U. S. Army Medical Department Activity, Fort George G. Meade

**MOD**
medical officer of the day

**MTF**
medical treatment facility

**NCOIC**
noncommissioned officer in charge

**NESD**
Nursing Education and Staff Development

NOD
nurse of the day

### Section II
### Terms

**Arrest**
A cardiac and or pulmonary arrest.

**Code**
An alternate term for Code Blue

**Code Blue**
A term used to describe a cardiac and or pulmonary arrest.

## CRASH CART INSPECTION CHECKLIST

*(For use of this form, see MEDDAC/DENTAC (Ft Meade) Regulation 40-24.)*

| Unit: | | | | | | | Month: | | | Year: | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Day of month | Cart lock number | Cart expiration date | Change 360J | Defibrillator pads | Electrodes | Paddles | O2 psi | Ambu-bags | Code sheets | Pacing pads | Initials |
| 1 | | | | | | | | | | | |
| 2 | | | | | | | | | | | |
| 3 | | | | | | | | | | | |
| 4 | | | | | | | | | | | |
| 5 | | | | | | | | | | | |
| 6 | | | | | | | | | | | |
| 7 | | | | | | | | | | | |
| 8 | | | | | | | | | | | |
| 9 | | | | | | | | | | | |
| 10 | | | | | | | | | | | |
| 11 | | | | | | | | | | | |
| 12 | | | | | | | | | | | |
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| 14 | | | | | | | | | | | |
| 15 | | | | | | | | | | | |
| 16 | | | | | | | | | | | |
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| 28 | | | | | | | | | | | |
| 29 | | | | | | | | | | | |
| 30 | | | | | | | | | | | |
| 31 | | | | | | | | | | | |

**MEDDAC (Ft Meade) Form 396-R, 1 Mar 99** Previous edition is obsolete.

# CODE BLUE AFTER ACTION REPORT

*(For use of this form, see MEDDAC/DCC (Fort Meade) Regulation 40-24)*

**NOTE:** This form is to be completed within 30 minutes of termination of the Code by the senior nurse and team leader physician involved and routed through the Code Blue Assessment Team within 24 hours of the resuscitation.

| 1. Patient's history/diagnosis: | 2. Date: | 3. Time: |
|---|---|---|
| | 4. Unit: | |

5. How was the Code Blue announcment made? ☐ Pager ☐ Public address system

6. Which members of the Code Blue Team responded to the announcement? *(A blank check box indicates the member did not respond.)*

☐ On duty UCC physician ☐ On duty UCC RN ☐ Internist ☐ Anesthesia Svc staff member ☐ Respiratory therapist
☐ Nursing Services representative ☐ Pharmacist ☐ Pediatrician (for pediatric Codes only)

7. Type of arrest: ☐ Cardiac ☐ Respiratory ☐ Cardiopulmonary ☐ Other
_____

8. Suspected cause of arrest: ☐ Myocardial Infarction ☐ Pulmonary Edema ☐ Dysrhythmia ☐ Drug ☐ Anesthesia
☐ Other _____

9. Procedure.

a. Recognized by: ☐ Nurse ☐ Corpsperson ☐ Physician ☐ Other
_____

b. How recognized: ☐ No respiration ☐ No pulse ☐ Agonal gasps ☐ Unresponsiveness ☐ Alarm ☐ Monitor

c. Resuscitation was started by: ☐ Nurse ☐ Corpsperson ☐ Physician ☐ Anesthesia ☐ Other
_____

d. Cardiac arrest recognized within: ☐ 1 minute ☐ 2 minutes ☐ 3 minutes ☐ 4 minutes ☐ Unknown

e. Effective CPR established within: ☐ 1 minute ☐ 2 minutes ☐ 3 minutes ☐ 4 minutes ☐ 5 minutes

f. Method of artificial ventilation: ☐ Mouth to mask ☐ Bag/mask ☐ Bag-ET tube

10. Results.

a. Resuscitation was: ☐ Successful ☐ Unsuccessful If successful, respirations were: ☐ Spontaneous ☐ None ☐ Intubated

b. Consciousness: ☐ Conscious ☐ Unconscious ☐ Semi-comatose

11. c.

| ITEM(S) | PRESENT | ADEQUATE | INADEQUATE | SPECIFY |
|---|---|---|---|---|
| Monitor | | | | |
| ECG | | | | |
| Suction | | | | |
| Oxygen | | | | |
| Defibrillator | | | | |
| Resuscitator bags | | | | |
| Intubation equipment | | | | |
| Drugs | | | | |
| Other Supplies | | | | |

12. Patient identification:

13. Organization. Was the Code Blue Team Leader - Identified? ☐ Yes ☐ No Effective? ☐ Yes ☐ No

14. Was unit coverage adequate during the resuscitation? ☐ Yes ☐ No

15. What was the duration of the procedure? _____

16. What was the disposition of the patien? _____

17. Patient left in whose responsibility? _____

**GENERAL COMMENTS**

Team Leader:

Signature/Stamp:

Supervisor/Charge Nurse:

Signature:

**RISK MANAGEMENT COMMITTEE FOLLOW UP**

NOTE: Return this form to the Urgent Care Clinic after follow up procedure has been completed.

1. Condition 24 hours post-arrest: *(Check all that apply.)*

☐ Neurological deficit ☐ Fractured ribs/sternum ☐ Pneumothorax ☐ Respiratory insufficiency o Cardiogenic shock

☐ Return to pre-arrest status ☐ Stable, but not in pre-arrest status ☐ Other

_____

2. Survival: ☐ 24 hours ☐ 24-72 hours ☐ 1 week ☐ Discharged

3. Comments: